

Topic: Child Abuse for Rhode Island EMS Providers

Time: 45-60 minutes

Materials: Appropriate audio/visual support

References: R.I. General Laws, Chapter 40-11

Child Abuse and Neglect: A Prehospital Continuing Education and Teaching Resource (CD-ROM produced by The Center for Pediatric Emergency Medicine of

the New York University School of Medicine)

Objective: The individual will demonstrate a basic knowledge of recognizing, reporting, and

documenting child abuse in the pre-hospital setting from memory, without assistance,

to a written test accuracy of 70%.

Elements:

1. Describe the EMT's role in recognizing, reporting, and documenting child abuse and neglect.

2. Describe different forms of child abuse/neglect, including signs and symptoms that the EMT may encounter.

3. Identify notification requirements under RI law as they apply to the EMT.

4. List tools available to the EMT including protective custody by law enforcement, patient interview techniques, and CISD resources for EMS personnel handling abuse cases.

5. Demonstrate proper procedures for thorough documentation of suspected abuse/neglect cases.

1 INTRODUCTION

- 1.1 Significance
 - 1.1.1 Child abuse and neglect are widespread, found across all levels of socioeconomic staus, all racial and ethnic (cultural) groups, and all religious affiliations.
 - 1.1.2 EMS providers are in a unique position to identify abuse and neglect.
 - 1.1.3 EMS providers have both a moral and legal obligation to report cases of abuse and neglect, whether suspected or confirmed.
- 1.2 EMS providers are society's first line of defense against child abuse and neglect they can be the eyes and ears of the medical community.
- 1.3 Abuse and neglect defined
 - 1.3.1 Abuse: A child has suffered physical or emotional injury inflicted by a caregiver (eg, parent, legal guardian, teacher, etc) that results in disability, disfigurement, mental distress, or risk of death.
 - 1.3.2 Neglect: A child's physical, mental, or emotional condition has been endangered because the caregiver has not provided for the child's basic needs.
- 1.4 The EMTs role in managing child abuse and neglect.
 - 1.4.1 Recognize signs/symptoms of abuse and neglect.
 - 1.4.2 Provide medical evaluation and treatment.
 - 1.4.3 Protect from further abuse.
 - 1.4.4 Report all cases of suspected abuse.
 - 1.4.5 Document all findings accurately, thoroughly, and legibly.

2 RECOGNITION

- 2.1 Importance of History
 - 2.1.1 Injury or illness inconsistent with history
 - 2.1.2 Critical to determine whether injury or illness could have been caused unintentionally or was inflicted
 - 2.1.3 Multiple visits to same household or previous visits for family violence
- 2.2 Right to Privacy
 - 2.2.1 Children have right to refuse
 - 2.2.2 Adolescents especially sensitive
 - 2.2.3 Do not examine unwilling child, especially if sexual abuse is suspected
 - 2.2.4 Give choices if possible
- 2.3 Physical Abuse
 - 2.3.1 Bruises
 - 2.3.1.1 Note location
 - 2.3.1.2 Infants rarely bruise accidentally
 - 2.3.1.3 Young, active children tend to incur bruises naturally on front of body (eg, knees, shins, elbows, forehead)
 - 2.3.1.4 Bruises in recognizable shape of object are suspect
 - 2.3.1.5 Multiple bruises in different stages of healing are suspect
 - 2.3.2 Skin Injuries
 - 2.3.2.1 Most common and easily recognized sign of abuse
 - 2.3.2.2 Conduct complete, thorough skin examination
 - 2.3.2.3 Always look for cuts, scrapes, bruises, burns, bites, redness, swelling
 - 2.3.2.4 Describe systematically and consistently when documenting
 - 2.3.3 Burns
 - 2.3.3.1 Scald burns common
 - 2.3.3.2 Two general patterns: immersion and splash
 - 2.3.3.3 Immersion burns characterized by clear lines of demarcation *Examples:* "Donut" pattern burn on buttocks or stocking/glove pattern burns of arms or lower legs
 - 2.3.3.4 Accidental burns more often have splash marks as child withdraws from heat source
 - 2.3.3.5 Inflicted contact burn
 - 2.3.3.6 Recognized by shape that duplicates object used to produce it (eg, cigarette, curling iron)
 - 2.3.3.7 Tend to be in less exposed areas, deeper, larger
 - 2.3.3.8
 - 2.3.4 Bites
 - 2.3.4.1 Adult human bite marks strongly suggest abuse
 - 2.3.4.2 In general, bite marks are multiple, random, well defined
 - 2.3.4.3 No one tooth mark stands out (differing from animal bites)
 - 2.3.5 Fractures
 - 2.3.5.1 Fractures discovered "accidentally"
 - 2.3.5.2 Skeletal injury inconsistent with history
 - 2.3.5.3 Multiple fractures in different stages of healing
 - 2.3.5.4 Accompanied by other injuries
 - 2.3.6 Falls

- 2.3.6.1 Fall from standing position or low object (less than child's height) rarely results in serious injuries
- 2.3.6.2 Fall from greater than child's height usually required to sustain serious injury
- 2.3.7 Injuries to face and head
 - 2.3.7.1 Unintentional injuries usually involve front of body
 - 2.3.7.2 Specific injuries to side of face, cheeks, ears suspicious of abuse
 - 2.3.7.3 Direct blow to mouth usually results in lip tear, possibly with broken jaw or teeth
 - 2.3.7.4 Considerable force required to cause severe head trauma
- 2.3.8 Hair Loss
 - 2.3.8.1 Can be manifestation of child abuse
 - 2.3.8.2 May be self-inflicted to relieve stress
 - 2.3.8.3 Can be caused by dragging child by hair, using excessive force during brushing, or certain types of hair braiding
 - 2.3.8.4 Often blood at the surface or beneath scalp
- 2.3.9 Shaken Baby Syndrome
 - 2.3.9.1 Most common in children less than 2 years old
 - 2.3.9.2 May be no evidence of external trauma
 - 2.3.9.3 Possible signs include decreased consciousness, seizures, vomiting, other signs of head injury, unusual cry
 - 2.3.9.4 Altered mental status may be only sign
 - 2.3.9.5 Recognizing the possibility should trigger suspicion of abuse

2.4 Sexual Abuse

- 2.4.1 Frequently thought of as occurring recently (within last 72 hours)
 - 2.4.1.1 In these cases, signs may include pain, bleeding, or discharge from urethra, vagina, or rectum
- 2.4.2 Can also be insidious, chronic, "hidden" abuse occurring over weeks or months
 - 2.4.2.1 In these cases, signs may include nonspecific abdominal pain, vaginal inflammation, or painful urination
- 2.4.3 Physical examination normal in most cases
- 2.4.4 Treatment of sexually abused patients:
 - 2.4.4.1 Believe what the child says
 - 2.4.4.2 Use the child's own words and document statements in quotes
 - 2.4.4.3 Never examine unwilling child
 - 2.4.4.4 Do not remove child's clothing or examine genitals unless severe genital pain or gross genital bleeding
 - 2.4.4.5 Refer child to specialist for examination

2.5 Emotional Abuse

- 2.5.1 A component of all forms of child abuse
- 2.5.2 Attack on child's development of self and social competence
- 2.5.3 May not be done on conscious level
- 2.5.4 Most cases mild, but early recognition important
- 2.5.5 Ignoring the child
- 2.5.6 Rejecting the child's needs and requests
- 2.5.7 Isolating the child
- 2.5.8 Verbally assaulting the child (eg, name-calling, harsh threats)
- 2.5.9 Encouraging destructive, antisocial behavior

2.6 Neglect

- 2.6.1 Most common form of child abuse
- 2.6.2 Likely most under-recognized and under-reported form of child abuse
- 2.6.3 Neglected children suffer greatly, often left with emotional scars
- 2.6.4 Inadequate care, including inadequate provision of food, clothing, or shelter
- 2.6.5 Inadequate medical attention, including delay in seeking care for known illness *Example:* While child is having asthma attack, mother leaves home to go shopping.
- 2.6.6 Signals to watch for
 - 2.6.6.1 Poor personal hygiene
 - 2.6.6.2 Unsanitary conditions
 - 2.6.6.3 Inadequate sleeping arrangements
 - 2.6.6.4 Lack of supervision
 - 2.6.6.5 Evidence of substance abuse
 - 2.6.6.6 Structural, fire, environmental hazards

2.7 Munchausen Syndrome by Proxy

- 2.7.1 Bizarre and rare form of child abuse
- 2.7.2 Illness in child is repeatedly induced by parent or other caregiver, who denies knowledge of cause
- 2.7.3 Symptoms subside when child is separated from parent or caregiver
- 2.7.4 Child should not be left alone with parent or caregiver

2.8 Cultural Considerations

- 2.8.1 Childrearing practices greatly influenced by culture *Examples:* babies allowed to cry themselves to sleep, children sleeping in parents' bed for several years
- 2.8.2 Practice considered abuse in one culture may be norm in another *Examples:* scarification of face, physical discipline
- 2.8.3 Cultural differences may affect evaluation of case
- 2.8.4 Important to be aware of other cultures in own community
- 2.8.5 Families may not realize that certain practices are considered abuse in US

2.9 Folk Medicine Practices

- 2.9.1 May mimic abuse
- 2.9.2 Should not be reported as abuse (usually)
- 2.9.3 Examples:
 - 2.9.3.1 Coin rubbing rubbing a coin along the skin may produce bruise-like rash
 - 2.9.3.2 Cupping applying heated cup to skin and pulling off after suction develops; causes circular bruises
 - 2.9.3.3 Moxibustion treatment related to acupuncture in which lighted objects placed on skin result in burns

2.10 Communicating with Caregivers (parents, guardians, etc.)

- 2.10.1 The primary goal is to protect the child from further injury.
- 2.10.2 Accusation and confrontation delay transportation.
- 2.10.3 Families likely to react negatively
- 2.10.4 Best to discuss in a place where assistance is immediately available
- 2.10.5 Police presence may be desirable

3 REPORTING

- 3.1 Reports must be made when child abuse or neglect is suspected or there is reasonable cause to believe that child abuse or neglect has occurred
- 3.2 Proof is NOT required
- 3.3 Reasonable Cause: When through training and experience, or physical evidence observed or described, the prehospital provider becomes aware of the possibility that neglect or nonaccidental means might be the cause of an injury.
- 3.4 The reasons for reporting are:
 - 3.4.1 to determine whether or not an investigation will ensue
 - 3.4.2 to determine whether or not abuse or neglect occurred
 - 3.4.3 to determine what happened and who is responsible
 - 3.4.4 to safeguard the child from future injury
- 3.5 The EMT's legal obligations under RI law
 - 3.5.1 All states have a reporting statute for child abuse and neglect
 - 3.5.2 Rhode Island's requirements established by *RIGL Chapter 40-11: Abused and Neglected Children*
 - 3.5.2.1 Lead agency is the RI Department of Children, Youth, and Families
 - 3.5.2.2 Any person with reasonable cause to know or suspect child abuse/neglect must report such to DCYF within 24 hours
 - 3.5.2.3 Immediate notification to DCYF required for parents of an infant who have requested
 - 3.5.2.3.1 deprivation of nutrition necessary to sustain life
 - 3.5.2.3.2 deprivation of medical or surgical interventions necessary to remedy or ameliorate a life-threatening condition (may not apply to terminally ill children if treatment would be ineffective)
 - 3.5.2.4 Any person with reasonable cause to know or suspect a child has died as a result of abuse or neglect must immediately notify DCYF
 - 3.5.2.5 RI law makes person making such a report in good faith is immune from civil or criminal liability
 - 3.5.2.6 Failure to report or actions to prevent someone else from reporting is a misdemeanor with a fine of up to \$500 or imprisonment of up to 1 year. Such individuals are alse civilly liable for damages caused by their failure to report.

3.6 Procedures

- 3.6.1 Who to notify
 - 3.6.1.1 Always DCYF via 24-hour hotline: 1-800-RI-CHILD (800-742-4453)
 - 3.6.1.2 Local law enforcement
 - 3.6.1.3 Hospital staff (when transporting patient)
- 3.6.2 When: as soon as possible (immediately in some cases, 24 hours in other cases)
- 3.6.3 What information to convey
 - 3.6.3.1 Provide name, address, age, sex, ethnicity of child
 - 3.6.3.2 Provide names and addresses of parents or caregivers legally responsible for child who are accused of abuse or neglect
 - 3.6.3.3 Identify yourself and how you may be contacted
 - 3.6.3.4 Explain why abuse or neglect is suspected
 - 3.6.3.5 Describe nature and extent of injuries, prior injuries, other children at risk

3.6.3.6 Report all actions taken *Examples*: "Child transported to hospital", "Child placed in protective custody", "Medical examiner notified"

3.7 Transfer of Care

- 3.7.1 EMS providers should indicate suspicion of abuse or neglect to emergency department personnel
- 3.7.2 Hospital personnel will examine child, meet with parent or caregiver, request social work evaluation (if available), and often make independent evaluation of need to report
- 3.7.3 Hospital action does not negate EMS provider's assessment and does not relieve EMS provider of reporting responsibility.
- 3.7.4 Child protection services may request child remain in emergency department until they can interview child and parents or caregivers
- 3.7.5 Child protection services may release child from emergency department to go home with parents or caregivers

3.8 Additional Actions

- 3.8.1 Document that call or written report was made
- 3.8.2 Provide all information to the health care provider who receives child
- 3.8.3 May be appropriate to also report case to police

4 TOOLS FOR EMTs

- 4.1 Protective custody by law enforcement
- 4.2 Interview techniques
 - 4.2.1 Ask open-ended questions only *Examples:* "What happened?", "How did you get hurt?"
 - 4.2.2 Allow child to explain in own words
 - 4.2.3 Avoid leading or suggestive questions *Example:* "Did Daddy hit you?"
 - 4.2.4 Do not force child to make statement
- 4.3 CISD for emotional consequences to EMS personnel handling abuse

5 DOCUMENTING

- 5.1 Purpose of documentation
 - 5.1.1 Protect the patient and other children
 - 5.1.2 Detection of abuse and prevent future episodes
 - 5.1.3 Accurately recalling observations and actions taken
 - 5.1.4 Protect EMS providers from legal liability
- 5.2 Evidentiary value
 - 5.2.1 Information most important!
 - 5.2.2 Documentation must be clear, accurate, detailed, thorough
 - 5.2.3 Diagrams very helpful
 - 5.2.4 Preserve physical and trace evidence when possible
- 5.3 By recognizing and documenting child abuse or neglect, EMS can save children's lives.
- 5.4 In what format
 - 5.4.1 Descriptive terms
 - 5.4.2 Objective and specific
 - 5.4.3 Use direct quotes wherever possible
- 5.5 Basic information to include
 - 5.5.1 Provide name, address, age, sex, ethnicity of child
 - 5.5.2 Provide names and addresses of parents or caregivers legally responsible for child who are accused of abuse or neglect
 - 5.5.3 Identify yourself and how you may be contacted

- 5.5.4 Explain why abuse or neglect is suspected
- 5.5.5 Describe nature and extent of injuries, prior injuries, other children at risk
- 5.5.6 Report all actions taken
 - 5.5.6.1 *Examples:* "Child transported to hospital", "Child placed in protective custody", "Medical examiner notified"
- 5.6 Documenting the Scene
 - 5.6.1 Use descriptive terms
 - 5.6.2 Avoid words that imply opinion or judgment *Example:* "garbage on floor, spoiled food on counter" is more useful than "dirty apartment"
 - 5.6.3 Describe scene rather than interpret it
 - 5.6.4 Document who is present, their condition, and any actions they have taken Example: "parent slurring words, smells of alcohol" is more useful than "parent drunk"
- 5.7 Documenting History/Presentation
 - 5.7.1 Document all versions of history as given by child, caregiver, other witnesses; use direct quotes
 - 5.7.2 Note if history is inconsistent with child's injuries
- 5.8 Documenting Statements by the Child
 - 5.8.1 Record child's statement word for word in quotes
 - 5.8.2 Include circumstances of statement (eg, who was present)
 - 5.8.3 Note child's actions and demeanor (eg, crying, withdrawn)
 - 5.8.4 Record any questions asked, who asked them, and response
- 5.9 Documenting Statements by Others
 - 5.9.1 Identify person making statement and record statements word for word in quotes
 - 5.9.2 Include circumstances of statement (eg, whether statement was made in response to a question, who else was present, how the person acted)
- 5.10 Documenting Additional Victims
 - 5.10.1 Same principles of documentation apply
 - 5.10.2 Document any statements made by or about other child suspected to be victim of abuse or neglect
 - 5.10.3 Document any actions taken regarding this child
- 5.11 Confidentiality
 - 5.11.1 Under RI law, all records concerning reports of child abuse and neglect, including reports to DCYF, are confidential
 - 5.11.2 Under RI law, communications are not priviledged between husband and wife and any professional person and his/her patient or client when related to known or suspected child abuse or neglect
- 6 ADDITIONAL HELP
 - 6.1 DCYF: 1-800-RI-CHILD (800-742-4453) nationwide, 24 hours
 - 6.2 Childhelp USA® National Child Abuse Hotline: 1-800-4-A-CHILD®
 - 6.3 RI Department of Health, Division of EMS, at (401) 222-2401
- 7 FINAL EXAMINATION
 - 7.1 Written post-test (20 questions)

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